Washington State Department of Social & Health Services
DASA Division of Alcohol & Substance Abuse

VIVITROL® IM PHYSICIAN PRIOR AUTHORIZATION

ATTENTION

To be considered eligible for reimbursement for **Vivitrol® IM** complete Sections 1 through 4 of the form and fax it to the Department of Social and Health Services (DSHS), Health and Recovery Services Administration's (HRSA) Prior **Authorization Fax Line (360) 725-2122**. Instructions for proper completion are on page three of this form.

1. CHEMICAL DEPENDENCY TREATMENT AGENCY SECTION

DIVISION OF ALCOHOL AND SUBSTANCE ABUSE (DASA) CERTIFIED CHEMICAL DEPENDENCY TREATMENT AGENCY	AGENCY NUMBER (Use Number in Greenbook "Directory of Certified Services in Washington")
DATE ADMITTED TO CHEMICAL DEPENDENCY TREATMENT	AGENCY TELEPHONE NUMBER

Verification

The certified chemical dependency treatment agency above verifies that the patient below: (a) is eighteen (18) years of age or older; (b) is alcohol dependent; and (c) has been admitted to a state-certified chemical dependency treatment agency. The Chemical Dependency Professional (CDP) providing services to this patient recommends referral to the physician named below to determine the use of **Vivitrol® IM** as a part of the patient's treatment plan.

CDP'S SIGNATURE	CDP'S PRINTED NAME	DATE

2. PATIENT SECTION

PATIENT AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

PATIENT NAME	PATIENT MEDICAID PIC NUMBER

The above-named patient hereby authorizes the following entities:

- the CDP and/or certified chemical dependency treatment agency in Section 1 above, and
- the Department of Social and Health Services – Division of Alcohol and Substance Abuse (DASA), and
- the Department of Social and Health Services – Health and Recovery Services Administration (HRSA), and
- the physician named in Section 3 below, and
- the pharmacy named in Section 4

to exchange and disclose to one another information concerning the patient's name and other personal identifying information, their status as a patient, diagnosis, recommended medication(s) and the treatment recommendations(s).

The purpose of this authorization for disclosure is:

- To initiate an authorization to obtain a prescription for **Vivitrol® IM** and coordinate care.
- To verify patient's involvement in state-certified chemical dependency treatment.

I understand that my alcohol and/or drug treatment records are protected under Federal and State confidentiality regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: six (6) months from the date signed or the **following specific date, event, or condition upon which this consent expires:**

(Specify the date, event, or condition)._____

I understand that the chemical dependency treatment agency named above might deny services if I refuse to consent to a disclosure for the purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied chemical dependency treatment services if I refuse to consent to a disclosure for other purposes.

PATIENT'S SIGNATURE	DATE	SIGNATURE OF GUARDIAN OR AUTHORIZED REP (WHEN REQUIRED)	DATE

3. PHYSICIAN SECTION			
PATIENT'S NAME		PHYSICIAN'S NAME	
PHYSICIAN'S ADDRESS	CITY	STATE	ZIP CODE
PHYSICIAN'S TELEPHONE NUMBER	FAX NUMBER	MEDICAID PROVIDER NUMBER	
DATE ORDERED	PROPOSED START DATE	**VIVITROL®** DOSE	EXPECTED DURATION OF THERAPY

Declaration

I understand that **Vivitrol® IM** must be administered by a licensed health care provider. Reimbursement by DSHS, HRSA for **Vivitrol® IM** is limited to twenty-six (26) weeks of continuous use and shall only be made under the following conditions as set forth in HRSA Numbered Memorandum 06-75.

	Yes	No
• Patient meets criteria for: ☐ Profile A ☐ Profile B		
• Is the patient diagnosed as Alcohol Dependent?	☐	☐
• Has the patient completed detoxification and achieved alcohol abstinence prior to beginning **Vivitrol® IM** treatment?	☐	☐
• Is patient currently using opioids?	☐	☐
• Does the patient have renal impairment?	☐	☐
If yes, what is the creatinine clearance? _____		
• Does the patient have acute hepatitis, liver failure, or active liver disease?	☐	☐
If yes, is ALT or ADT over three (3) times the upper limit of normal?	☐	☐
• Is **Vivitrol® IM** administered as part of a comprehensive chemical dependency Treatment program?	☐	☐
• What other treatment alternatives have been tried?		

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The efficacy of **Vivitrol® IM** in promoting abstinence has not been demonstrated in patients who have not completed detoxification and achieved alcohol abstinence prior to beginning **Vivitrol® IM** treatment.

PHYSICIAN'S SIGNATURE	DATE

4. PHARMACY SECTION		
PHARMACY NAME	TELEPHONE NUMBER	FAX NUMBER
PHARMACY ADDRESS	CITY	STATE ZIP CODE

I have verified that **Vivitrol® IM** will be dispersed to and administered by a health care provider in a medical facility: ☐ Yes ☐ No	NCPDP NUMBER	Rx NUMBER
PHARMACIST'S SIGNATURE		DATE

Information about Patient's Right to Revoke Authorization: A revocation requires only that a line be drawn through the document, with the word "Revoked," with the date and time of revocation. The patient need not initial a revocation. A patient may request revocation by any means, including over the telephone provided their identity is confirmed.

This notice should accompany all documents released under the Patient's Authorization for Confidential Information on Page 1.

NOTICE PROHIBITING REDISCLOSURE OF CONFIDENTIALALCOHOL OR DRUG TREATMENT INFORMATION

This notice accompanies a disclosure of information concerning a patient in alcohol/drug treatment, made to you with the consent of such patient. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR) Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

INSTRUCTIONS FOR VIVITROL® IM PHYSICIAN PRIOR AUTHORIZATION

This **Vivitrol® IM Physician Prior Authorization** form must be completed and submitted before administration of the medication in order for DSHS to pay for the medication. The Chemical Dependency Treatment Agency or the prescribing physician may initiate this form.

A. Complete **SECTION 1. CHEMICAL DEPENDENCY TREATMENT AGENCY SECTION:**

Enter the name of the DASA certified chemical dependency treatment agency and the agency's 8-digit certification agency identification number found in the "Directory of Certified Chemical Dependency Treatment Services in Washington State" (commonly known as the "Greenbook") published by DASA HRSA/DSHS, found at

- **http://www1.dshs.wa.gov/dasa/services/certification/GB.shtml.**
- Enter the date the patient was admitted to chemical dependency treatment and the agency telephone number.
- The patient's Chemical Dependency Professional (CDP) signs, dates, and assists the patient with Section 2.
- The CDP keeps a copy in the patient's record at the chemical dependency treatment agency.

B. Complete **SECTION 2. PATIENT SECTION:**

- Enter the patient's name and Medicaid Patient Identification Code (PIC) number.
- Complete the **Patient Authorization for Disclosure of Confidential Information,** being sure the CDP discusses this disclosure with the patient, have the patient sign, and date it (or their guardian or authorized representative, when required). Then the form goes to the Physician.

C. Complete **SECTION 3. PHYSICIAN SECTION:**

- Enter the name of the patient and physician.
- Enter the physician's address, telephone number, Fax number, Medicaid provider number, date ordered, proposed start date, dose, and expected duration.

Physician verifies the patient meets the criteria set forth in HRSA Numbered Memorandum 06-75 found at http://fortress.wa.gov/dshs/maa/download/memos/year2006.html by completing the declaration.

- The physician's office completes the **Vivitrol® IM Information for Patients, Physicians, Providers (VIP^3) verification and ordering form.** More information about verification and ordering can be found at **http://www.vivitrol.com/**
- The physician keeps a copy of the **Vivitrol® IM Physician Prior Authorization** form in the medical record.
- The physician's office faxes the completed **Vivitrol® IM Physician Prior Authorization** form to the specialty pharmacy.

D. Complete **SECTION 4. PHARMACY SECTION:**

- Enter the name of the pharmacy, telephone number, fax number, and address.
- Verify the medication is being dispensed to and administered by a health care provider in a medical facility.
- Pharmacist signs and dates the form.
- The pharmacy keeps a copy of the **Vivitrol® IM Physician Prior Authorization** form for their records.
- The pharmacy will fax the completed **Vivitrol® IM Physician Prior Authorization** form to the **HRSA Prior Authorization Fax Line (360) 725-2122** for authorization. This must be done before medication is dispensed and administered.

E. **Steps for Authorization or Denial by DSHS HRSA**

- Once the **HRSA Prior Authorization Fax Line (360) 725-2122** receives the completed **Vivitrol® IM Physician Prior Authorization** form, they will contact DASA to verify the patient's status in a state certified chemical dependency treatment program.
- Then HRSA will notify the physician's office or the pharmacy of approval or denial to pay.